Appendix A

Environmental Scan:

Unique Health Plan Identifier
And
Operating Rules for Health Information Transactions

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1.0 BACKGROUND

The Patient Protection and Affordable Care Act (PPACA) - HR 3590, also called the "Affordable Care Act," was enacted on March 23, 2010. It includes a large number of health-related topics including subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of health care benefits coverage for pre-existing conditions, expanding Medicaid eligibility, and establishing health insurance exchanges.

The Affordable Care Act also includes two sections related to administrative simplification (Sec. 1104) and standards for financial and administrative transactions (Sec. 10109). It calls for the National Committee on Vital and Health Statistics (NCVHS) to provide input into the process of rulemaking for the establishment of a unique health plan identifier and to provide advice and recommendations to the Department of Health and Human Services (HHS) relative to operating rules for electronic exchange of information not defined by a standard or its implementation specification.

2.0 INTRODUCTION

Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subtitle F – Administrative Simplification, called for "improving the . . . the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." Subsequently, rules have been issued to address the Administrative Simplification provisions, including those to support electronic exchange of healthcare financial and administrative transactions and standard unique health identifiers for each individual, employer, health plan, and health care provider.

2.1 Unique Identifiers

Standard Unique Employer Identifier was adopted May 31, 2002, becoming effective July 30, 2002. It utilizes the ''Employer identification number'' (EIN) as defined in 26 CFR 301.7701–12, with the exception of deleting the formatting description. The EIN is defined as ''the taxpayer identifying number of an individual or other person (whether or not an employer) which is assigned pursuant to 26 U.S.C. 6011(b) or corresponding provisions of prior law, or pursuant to 26 U.S.C. 6109, and in which nine digits are separated by a hyphen, as follows: 00–0000000.'' A covered entity must use the standard unique employer identifier (EIN) of the appropriate employer in standard transactions that require an employer identifier to identify a person or entity as an employer, including where situationally required.

Standard Unique Health Identifier for Health Care Providers was published January 23, 2004. The National Provider Identifier (NPI) is a 10-position numeric identifier, with a check digit in the 10th position, and no intelligence about the health care provider. The NPI must be used as described in the implementation specifications for providers (45 CFR § 162.410), health plans (45 CFR § 162.412), and health care clearinghouses (45 CFR § 162.414), and may be used for any other lawful purpose.

The rule creating the NPI also created a National Provider System that would assign a single, unique NPI to a health care provider (including subparts of a provider) and collect, maintain, and make available to the public information about each health care provider. The Department of Health and Human Services (HHS) created the **National Plan and Provider Enumeration System (NPPES)** to enumerate providers. It is designed with the future capability to also enumerate health plans once a standard is adopted. The compliance date for using the NPI was originally May 23, 2007. As result of challenges in reprogramming systems and building crosswalks between NPIs and legacy numbers, HHS issued guidance on April 2, 2007 relative to implementing contingency plans to send or accept legacy provider numbers. The compliance date for use of the NPI was reset to May 23, 2008. CMS also distributed a National Provider ID Data Dissemination Policy to notify covered entities which data elements about a provider would be available through the NPPES. In response to public comment objecting to the risk to providers if certain data elements were made public, HHS provided an amnesty period for providers to remove information they deemed sensitive. Provider data became publically available on September 4, 2007.

Standard unique health plan identifier has not yet been adopted, hence the inclusion in the Affordable Care Act. Today, health plans, including workers' compensation plans, self-create or choose to use existing identifiers (such as TIN or EIN) and distribute them as proprietary numbers to be reported to that specific health plan. State regulators and some companies that provide electronic transaction management use 5-digit codes assigned to commercial payers by the National Association of Insurance Commissioners (NAIC).The tax identification number (TIN) assigned by the Internal Revenue Service is another number that may be used to identify health plans. A single health plan can have several identifiers assigned by different organizations for specific purposes or because the same health plan organization is known by more than one name.

Unique individual identifier has been postponed for development. The NCVHS Ninth *Annual Report to Congress on the Implementation of the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act* (May 11, 2010) notes that "HIPAA requires HHS to develop a **unique personal identifier** for every individual patient in the country to improve processing and recordkeeping in healthcare systems and transactions. Members of Congress have since expressed strong reservations about the appropriateness of creating a new identifier for individuals that might be perceived as a "universal identifier," and since 1999, the Congress has prohibited expending funds for its development in HHS' appropriations legislation."[1]

2.2 Transactions and Code Sets

The HIPAA Administrative Simplification provisions included requirements for the adoption of standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically for specific financial and administrative transactions. A final rule adopting standards for eight electronic transactions and code sets (see Insert) to be used in those transactions was issued on August 17, 2000, with a final compliance date of October 2003. Based on a report from the Designated Standards Maintenance Organization (DSMO) in 2007 and subsequent recommendations by NCVHS, CMS published a final rule adopting newer versions of these standards for which all covered entities must be fully compliant on January 1, 2012.[2]

There are a number of challenges in implementing the transaction standards and their implementation specifications.

HIPAA Administrative Simplification Standards

Accredited Standards Committee (ASC) X12

270/271	Eligibility for a Health Plan (Inquiry and Response)
837	Claim or Equivalent Encounter Information (and Coordination of Benefits [COB])
276/277	Claim Status Inquiry and Response
835	Health Care Payment and Remittance Advice (Electronic Remittance Advice [ERA] and Explanation of Benefits [EOB])
278	Referral Certification and Authorization (Health Care Services Request for Review and Response)
834	Enrollment and Disenrollment in a Health Plan
820	Health Plan Premium Payment

National Council for Prescription Drug Programs (NCPDP)

5.1 & D.0	Telecommunication and batch standards for claims. eligibility, and authorization
3.0	Medicaid pharmacy subrogation

One challenge is the length of time between creation of new versions of standards and their being readied for adoption, as well as the lengthy rule making process. Recommendations for changes are to be brought to the Designated Standard Maintenance Organization (DSMO) Committee.

Designated Standard Maintenance Organization (DSMO) was established in the Standards for Electronic Transactions Final Rule, published August 17, 2000. This is a category of organization that the Secretary

[1] http://www.ncvhs.hhs.gov/100511hipaarpt.pdf
[2] 45 CFR Part 162 Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rules, Federal Register, January 16, 2009.

may designate to organizations that agree to maintain standards. These provisions within HIPAA also establish criteria for the processes to be used in such maintenance. Several Data Content Committees (DCCs) and Standard Setting Organizations (SSOs) have agreed to maintain those standards designated as national standards in the final rule "Standards for Electronic Transactions" according to the criteria established by the Secretary. These organizations include:

- Accredited Standards Committee X12
- Dental Content Committee of the American Dental Association (ADA)
- Health Level Seven (HL7)
- National Council for Prescription Drug Programs (NCPDP)
- National Uniform Billing Committee (NUBC)
- National Uniform Claim Committee (NUCC)

These DSMOs have formed a Committee to focus on managing HIPAA standard change requests. A web site helps meet that challenge by providing industry expertise and solutions that directly support several of the committee's guiding principles:

- Allow open public access
- Provide for timely review
- Cooperate and communicate
- Consider all viewpoints

Another challenge in implementing the transaction standards and their implementation specifications relates to the level of optionality embedded in the standards, which contributes to their not being adopted in a consistent and standardized manner. The need for such optionality arose from variations in state insurance laws, differences in telecommunications capabilities that have had to have been addressed, data formatting issues, and differing data content needs. The result has been the creation of companion guides that require providers to adhere to different rules for different health plans. In a presentation to NCVHS on April 6, 2005, Kepa Zubeldia reported that before HIPAA there were 400 different formats of the transactions in use, and that after HIPAA, his company identified that 1,082 companion guides had been.[3]

Given that such companion guides vary by health plans and that such variance can be confusing and costly to trading partners and providers, subsequent efforts have been made to reach consensus on a standard template/common structure and content for companion guides, and standard policies and operating rules for specific standards implementations. There is at least one national private sector initiative that has developed operating rules, starting with eligibility and claims status. This is the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE). There is at least one regional initiative, LINXUS, focusing on the greater New York and surrounding states, that has also developed operating rules or “implementation specifications” for eligibility, claims status, and remittance transactions. AHIP and BCBSA have implemented a pilot project wherein health plans in two states (Ohio and New Jersey) have come together to offer a single website for providers to connect with most of the health insurers for administrative functions. There are also several states that have addressed standardizing companion guides, developing operating rules, or otherwise taking a leadership role in streamlining provider/payer interactions through the voluntary adoption of best practices. Among these states, Minnesota and Washington provided testimony to NCVHS on this topic.

3.0 PURPOSE OF ENVIRONMENTAL SCAN

The purpose of this environmental scan is to establish baseline knowledge describing the current state with respect to the unique health plan identifier and operating rules for claims status and eligibility verification. In its first draft, it provides the Standards Subcommittee of the NCVHS:

[3] Zubeldia, Kepa. “From HIPAA to Interoperability,” HIPAA Transactions Convergence Project, presentation to NCVHS, April 6, 2005.

- Summary of the legislative mandate concerning the unique health plan identifier and operating rules for claims status and eligibility verification.
- List of terms associated with the unique health plan identifier and operating rules for claims status and eligibility verification, including definitions.
- Background information on the unique health plan identifier and operating rules for claims status and eligibility verification.
- Identification of key stakeholders with respect to the unique health plan identifier and operating rules for claims status and eligibility verification.
- Examples of identifiers and operating rules from other industries providing lessons learned.

As NCVHS hearings are held on July 19-21, 2010, the environmental scan may be updated and enhanced with additional information to provide background information for the NCVHS to develop its report and recommendations to the Secretary of HHS.

The environmental scan is intended to be impartial and unbiased. Inclusion of information in the first draft is based upon literature review and stakeholder communications, with the second draft including information from verbal and written testimony supplied in response to the *Federal Register* notice of hearings. Exclusion of representative information is not intentional; but constrained by time or inability to access information. Readers are encouraged to submit information in response to the notice of hearings.

4.0 LEGISLATIVE REQUIREMENTS FOR ADMINISTRATIVE SIMPLIFICATION FROM THE AFFORDABLE CARE ACT

The Affordable Care Act addresses administrative simplification in two sections:

4.1 Sec. 1104. Administrative Simplification

This section of the Affordable Care Act provides for amendment, adoption, promulgation, and expansion of rules relative to HIPAA's Administrative Simplification provisions. In general, the statute requires:

- Amendment the HIPAA Administrative Simplification provisions to clarify that *uniform* standards are intended to *reduce the clerical burden on patients, health care providers, and health plans*.
- Adoption a single set of operating rules for each health information transaction
- Adoption a new standard for electronic funds transfer (EFT) (see insert)
- Promulgation of rules for:
  - Unique health plan identifier (based on input of the NCVHS, and which may be an interim final rule that becomes effective by October 1, 2012)
  - Electronic funds transfer (which may be as an interim final rule by January 1, 2012 that is effective by January 1, 2014)
  - Health care claims attachments (which may be as an interim final rule by January 1, 2014 that is effective by January 1, 2016)
- Amendment the Social Security Act to expand electronic transactions in Medicare to require not later than by January 1, 2014 payment under part A or part B as either by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Legislative Requirements for Standards and Operating Rules
In general, standards and associated operating rules shall: 1. enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care; 2. be comprehensive, requiring minimal augmentation by paper or other communications; 3. provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and 4. describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit

additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse)	
Operating rules development shall be conducted by a qualified nonprofit entity that meets specific requirements (see Insert page 18).	
Adoption of operating rules:	**Timeline**
• Eligibility for a health plan and health claim status	Adopted by July 1, 2011 Effective* by January 1, 2013
• Electronic funds transfers and health care payment and remittance advice	Adopted by July 1, 2012 Effective* by January 1, 2014
• Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization	Adopted by July 1, 2014 Effective* January 1, 2016
• Health claims attachments (standard and operating rules)	Adopted by January 1, 2014 Effective* by January 1, 2016
Compliance with standards and operating rules (as initially promulgated and as may be revised), including documentation of compliance, service contract compliance with certification requirements, designation of an outside certification entity, periodic audits by the Secretary)	
• Health plan certifies that its data and information systems are in compliance with applicable standards and operating rules for: ○ eligibility for a health plan ○ health claim status ○ electronic funds transfer ○ health care payment and remittance advice	Not later than* December 31, 2013
• Health plan certifies that its data and information systems are in compliance with applicable standards and operating rules for: ○ health claims or equivalent encounter information ○ enrollment and disenrollment in a health plan ○ health plan premium payments ○ health claims attachments ○ referral certification and authorization	Not later than* December 31, 2015
Review and recommendations for amendment of standards and operating rules by a review committee (which may be NCVHS, and which must be coordinated with standards recommended by the HIT Standards Committee that supports certified electronic health record [EHR] technology approved by Office of the National Coordinator [ONC]), must: • be promulgated as an IFR 90 days after receipt of report • include public comment received within 60 days of IFR publication • become effective within 25 months of the close of the public comment period	Not later than* April 1, 2014 and biennially thereafter
Penalties shall be assessed against a health plan that has failed to meet the standards and operating rules requirements	Not later than* April 1, 2014 and annually thereafter

* Date of compliance – a health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule

4.2 Sec. 10109. Development of Standards for Financial and Administrative Transactions

This section enables the development of additional transaction standards and operating rules. It requires the Secretary of HHS to solicit input by January 1, 2012 and not less than every 3 years thereafter from NCVHS, HIT Policy Committee, HIT Standards Committee, and standard setting organizations on:

- whether there could be greater uniformity in financial and administrative activities and items as determined by the Secretary, and

- whether such activities should be considered financial and administrative transactions for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

The additional activities and items for initial consideration include:

- Standard, electronic enrollment of health care providers by health plans
- Application of standards and operating rules to the health care transactions of automobile insurance, worker's compensation, and other programs or persons
- Standardization of financial audits required by health plans, Federal and State agencies, and other relevant entities
- Greater transparency and consistency of methodologies and processed used to establish claim edits by health plans

In addition, this section tasks the ICD-9-CM Coordination and Maintenance Committee to receive input and make recommendations about appropriate revisions regarding the crosswalk between the Ninth and Tenth Revisions of the ICD-9 and ICD-10, treat any revised crosswalk as a code set for which a standard has been adopted by the Secretary, and post a crosswalk for subsequent versions of ICD not later than the date of implementation of the such subsequent revisions.

4.3 Sec. 1561. Health Information Technology Enrollment Standards and Protocols

This section amends Title XXX of the Public Health Service Act to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, including providing individuals notification and verification of eligibility. The standards and protocols shall allow for electronic matching against existing Federal and State data, simplification and submission of electronic documentation, reuse of stored eligibility information, capability for individuals to manage their eligibility information online, ability to expand the enrollment system to integrate new programs, notification of needed communications concerning eligibility, and other functionalities.

No specific mention is made of the standards including use of the unique health plan identifier.

5.0 DEFINITIONS ASSOCIATED WITH TRANSACTIONS AND CODE SETS

In general terms, a technical standard is an established norm or requirement. It is usually a formal document that establishes uniform engineering or technical criteria, methods, processes, and practices.

HIPAA's Administrative Simplification regulation text provides specific definitions for a number of terms associated with the transactions and code sets:

> **Standard** has been defined within HIPAA as "a rule, condition, or requirement:
> (1) Describing the following information products, systems, services or practices:
> (i) Classification of components.
> (ii) Specification of materials, performance, or operations; or
> (iii) Delineation of procedures; or
> (2) With respect to the privacy of individually identifiable health information."
>
> **Standard transaction** means a transaction that complies with an applicable standard adopted [under HIPAA].
>
> **Implementation specification** within HIPAA's Administrative Simplification regulation text is defined as "specific requirements or instructions for implementing a standard." As applicable to the standard transactions, the ASC X12 standards are embodied within Implementation Guides (IGs). It is noted that data elements within the IGs have been described as "required," "not used," and "situational," as defined below. The term "**conditional**" with respect to data elements is in ASC X12, but has not applied to HIPAA. However, the Affordable Care Act includes in Sec. 1104 (b) Operating Rules for

Health Information Transactions (4)(A)(iv) the requirement that the Standards and Operating Rules (italics added for emphasis) "describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be *required or conditional* upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse)."

Required means the item must be used to be compliant with the IG.

Not used means the item should not be used when complying with the IG.

Situational means the item should be used whenever the situation defined in the note is true; otherwise, the item should not be used. The defining rule is generally documented in a syntax or usage note attached to the item. If no rule appears in the notes, the item should be sent if the data is available to the sender. Use of this item varies, depending on data content and business context.

Trading partner agreement "means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conduct a standard transaction."

The Affordable Care Act defines operating rules as follows:

Operating rules "means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part."

Companion guide is another type of guiding document currently in use relating to the standard transactions. CMS[4] provides the following description of companion guides and cites the HIPAA Administrative Simplification regulation text requirements for trading partner agreements (§162.915):

Companion guides are "health plan-specific versions of the HIPAA-adopted standard Implementation Guides that define the health plans' requirements for situational data elements, and provide special instructions and further guidance on how the health plan is interpreting the HIPAA Implementation Guides. While HIPAA adopted specific Implementation Guides, Companion Guides have been independently created by some health plans to supplement the Guides and are tailored to meet individual health plans' particular needs. Companion Guides are not required by HIPAA, and all health plans are not publishing Companion Guides."

[Per 45 CFR §162.915] these guides cannot:
(a) Change the definition, data condition, or use of a data element or segment in a standard.
(b) Add any data elements or segments to the maximum defined data set.
(c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s).
(d) Change the meaning or intent of the standard's implementation specification(s).

6.0 DEFINITIONS ASSOCIATED WITH HEALTH PLAN

Pertinent to the discussion of a unique health plan identifier, the definition of health plan is important in identifying all entities that must be enumerated.

[4] https://questions.cms.hhs.gov/app/answers/detail/a_id/4208/~/what-are-companion-guides%3F-where-do-i-get-them%3F

6.1 CMS Definition of Health Plan

CMS considers a health plan to be an entity that stands in a relationship to an individual that legally obligates it to pay claims for some or all of the health care provided to the individual. Specifically, health plan includes a private or governmental form of health insurance, in which the plan has the responsibility to pay the health claims for health care provided to a beneficiary who has either enrolled in the plan or met other eligibility conditions for benefits, pursuant to a contract or other legal arrangement (*e.g.*, a statute, regulation) that identifies, provides for the funding of, and creates an obligation to pay for, benefits.

It can be construed that an entity that is not otherwise captured as one of the health plans listed in the statutory definition comes within the residual definition of health plan if it bears the payment responsibility for the health claims for health care provided to a beneficiary who has either enrolled in the plan or met other eligibility conditions for benefits, pursuant to a contract or other legal arrangement (*e.g.*, a statute, regulation) that identifies, provides for the funding of, and creates an obligation to pay for, benefits.

The term applies to private sector entities that function as health insurers and to public sector, governmental entities that function as payers in the health care system with respect to the health care provided to identified and/or identifiable beneficiaries (e.g. members, subscribers and their dependents).

6.2 Statutory Definition of Health Plan

Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C 300gg-91(a)(2)).
(1) Health plan includes the following, singly or in combination:
- (i) A group health plan.
- (ii) A health insurance issuer.
- (iii) An HMO.
- (iv) Parts A, B, or C of the Medicare program.
- (v) The Medicaid program.
- (vi) An issuer of a Medicare supplemental policy.
- (vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.
- (viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- (ix) The health care program for active military personnel.
- (x) The veterans health care program.
- (xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
- (xii) The Indian Health Service program under the Indian Health Care Improvement Act.
- (xiii) The Federal Employees Health Benefits Program.

6.3 Regulatory (§160.103) Definition of Health Plan

- (xiv) An approved State child health plan, providing benefits for child health assistance.
- (xv) The Medicare+Choice program.
- (xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- (xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.

6.4 Other Definitions and Applicable Terms Associated with Health Plans

HIPAA Administrative Simplification regulation text also defines group health plan and health insurance issuer:

> ***Group health plan*** is "an employee welfare benefit plan (as defined in the Employee Retirement Income and Security Act of 1974 [ERISA]), including insured and self-insured plans, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or

their dependents directly or through insurance, reimbursement, or otherwise, that has 50 or more participants or is administered by an entity other than the employer that established and maintains the plan."

Health insurance issuer means (as also defined in 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(b)(2)) "an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan."

Black's Law Dictionary (7th ed. 1999) can also be referenced with the following generally accepted definition:

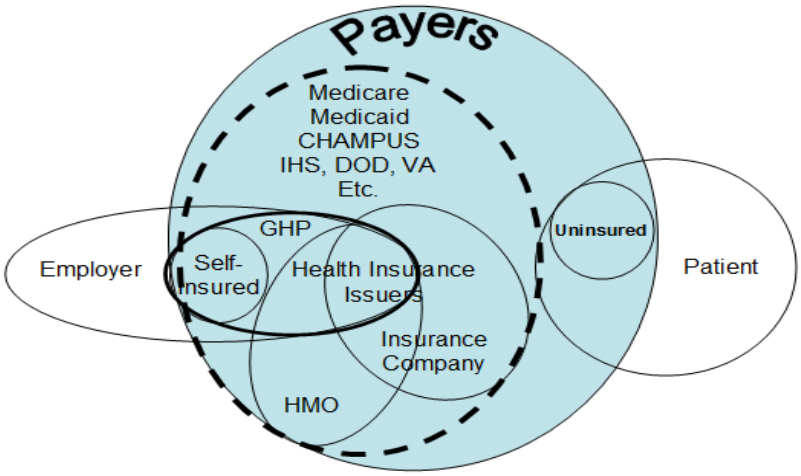
Insurance is "an agreement by which one party (the *insurer*) commits to do something of value for another party (the *insured*) upon the occurrence of some specified contingency; … an agreement by which one party assumes a risk faced by another party in return for a premium payment."

The Affordable Care Act indicates that the term health plan means "health insurance coverage and a group health plan," and that the term "shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under ERISA."

It also clarifies that health insurance issuer and group health plan have the same meanings as defined within the HIPAA Administrative Simplification regulation. These definitions are provided in the Affordable Care Act under the section relating to *Qualified Health Plans*. A **qualified health plan** provides specified "essential health benefits package and is offered by a health insurance issuer that is licensed and in good standing to offer health insurance coverage in each State…; agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such [American Health Benefit] Exchange…," which is a State-based operation that facilitates the purchase of qualified health plans and provides for assisting qualified employers in enrolling their employees in such plans.

As such, "health plan" appears to be defined within the Affordable Care Act in a manner equivalent to that in the HIPAA Administrative Simplification regulation text and 2791(a)(2) of the Public Health Service Act, 42 U.S.C.

Payer is a term often used synonymously with health plan. The CMS online glossary defines payer as "an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO."[5] This definition, attempted to be illustrated in the figure below, suggests that payer is broader than health plan.



[5] Centers for Medicare & Medicaid Services Glossary, www.cms.gov/apps/glossary, last updated 05/14/06, accessed June 20, 2010

6.4 Use Case Describing Entities involved in Financial and Administrative Transactions

In addition to the overarching program of paying the cost of medical care (health plan) and the entity/person providing the payment (payer), there are multiple health plan products supplied by health plan entities, and multiple entities involved in carrying out financial and administrative transactions. To illustrate this, the following use case has been drafted. This use case is only for illustrative purposes, and does imply any intent or recommendations.

Transaction Routing	Purpose	Examples of Alternatives/ Exceptions
1. Health plan	Enrollment in and premium payment to for health plan coverage	
2. Third party administrator	Provider contracts with	Employer, trust
3. Product	Individual buys	ASO, PPO, HMO, indemnity, high-deductible plan, etc.
4. Benefit/Fee schedule	Amount payer pays	BCBS and Medicare provide benefit/fee schedule at local level
5. Repricer (applies to 837)	Where claim is sent	Billing company, clearinghouse
6. Health plan	Where money comes from	Trust or government

7.0 UNIQUE HEALTH PLAN IDENTIFIER

Unique health plan identifier rule is required to be promulgated under the Affordable Care Act, based on the input of the NCVHS. The Secretary of HHS may do so on an interim final basis and such rule shall be effective not later than October 1, 2012. The term “effective date” means the compliance date for this and all rules to be published under the ACA legislation.

7.1 Definition of Unique Health Plan Identifier

The Affordable Care Act references HIPAA Administrative Simplification provisions for the unique health plan identifier:

> **Unique Health Identifiers:** “The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.”

CMS’s Glossary defines National Payer ID, pre-HIPAA, as “a system for uniquely identifying all organizations that pay for health care services;” noting this is also known as Heath Plan ID, or Plan ID.

7.2 Purpose of Unique Health Plan Identifier

There is no further information in either HIPAA or the Affordable Care Act that describes the purpose of a unique health plan identifier. HIPAA only identifies that “in carrying out the [adoption of identifier standards], the Secretary shall take into account multiple uses for identifiers…”

However, a review of the literature and proposals that have been put forth both previously for the national provider identifier (NPI) and, to date, for the unique health plan identifier from various stakeholders reveals several issues associated with ***not*** having a unique health plan identifier:

- Inability to route transactions in a timely manner costs the health care industry time and money. Although referencing a standard health identification card which is broader (and out of scope for this

environmental scan) than the identifier alone, the Medical Group Management Association has estimated savings to physicians and hospitals from having *a standard health identification card* at $1 billion per year.[6]

- Increases the challenges in ensuring accurate and timely claims payment and reconciliation, often requiring manual intervention especially associated with the proliferation of increasingly complex types of health insurance products, benefit plans, and delivery vehicles.[7]
- Provider and patient/member dissatisfaction often arises with not knowing the eligibility of a patient for benefits because the process often requires manual intervention that is prone to error or is not performed due to time factors, with denied transactions due to insurance identification errors, and with difficulties in resolving insurance problems because it is difficult to pinpoint errors in the payment processing chain without a unique health plan identifier.[8]
- Difficulty in identifying a payer where there may be different contractual requirements for the provider with respect to different payer divisions with different names. This can result in the inability to resolve questions, especially surrounding coordination of benefits.[9]
- State and national health data organizations have a difficult time collecting accurate payer data for reporting purposes.[10]
- Reduction in the value of a standard health identification card, where the purpose is to provide uniformity in accessing health plan information (no personal health data).[11]

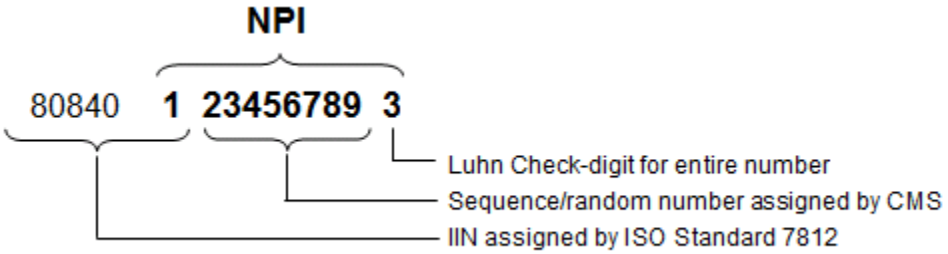
7.3 Related and Other Identifier Standards and Their Uses

ISO Standard 7812 is a standard that specifies card issuer numbers for major industries. The ISO standard includes three components:

- Issuer identifier number (IIN) that identifies the issuing organization. This is the first 6 digits following the ISO standard prefix, such as the first 6 digits on a bank charge card. ISO assigned 80840-0 through 80840-9 to HCFA (now CMS) in 1996. (The initial two numbers, 80, refer to health applications, and the last three numbers, 840, refer to the United States.)
- Individual account identification is a maximum of 12 digits.
- Check digit, calculated with the Luhn algorithm which is defined in Annex B of the ISO 7812 standard.

The ISO 7812 is used by many industries, including for the National Provider Identifier (assigned by CMS), National Council for Prescription Drug Programs (NCPDP) transactions, and credit cards.

- **National Provider Identifier (NPI)** is an ISO Standard U.S. Healthcare ID, of the following structure:



[6] MGMA and Humana urge industry to adopt standard, machine-readable patient ID cards, February 3, 2009.
[7] American Medical Association's National Health Plan Identifier White Paper (September 22, 2009).
[8] Peter Barry, Enumeron, 16th HIPAA Summit, Cambridge, August 20, 2008.
[9] American Association of Healthcare Administrative Management, Issue – National Payer Identification Number, March 23, 2010.
[10] American Association of Healthcare Administrative Management, Issue – National Payer Identification Number, March 23, 2010.
[11] WEDI Health Identification Card Implementation Guide, http://www.wedi.org/snip/public/articles/WEDI-Health-ID-Card-Approved.pdf

In the case of the NPI, CMS assigns the individual numbers.

With respect to the health plan identifier, in 2006 CMS released the "9 row" back to ISO for the private sector. Enumeron requested, and was ultimately assigned, the ISO number 80840-9 to use for a private sector effort for plan identification. Enumeron states that its mission is to issue PlanIDs and Trading partner IDs just like the NPI but to begin with "9,"[12] which plans would request on a voluntary basis.

- **National Council for Prescription Drug Programs (NCPDP)** provides the NCPDP Health Care Identification Card Pharmacy and/or Combination ID Card Implementation Guide Version 3.0.[13]

  Because the Guide is based on the INCITS 284 Standard for Health Care Identification Cards, it also follows the ISO Standard 7812. On behalf of the pharmacy industry, NCPDP has been issued card issuer identifier 9151014609, preceded by 80840 IIN, to be used on pharmacy-only ID cards.

  For routing purposes, NCPDP uses the ANSI International Identification Number (RxBIN) that provides complete electronic transaction routing information. The Processor Control (RxPCN) and Group Numbers (RxGrp) are mandatory when required by the benefit administrator to electronically route a prescription claim. The front of the pharmacy-only ID card includes the plan name or other identifying information. The back of the pharmacy-only ID card includes the name and address of the benefit administrator and telephone number for assistance. NCPDP strongly discourages the use of combination ID cards when the cardholder IDs and the group/account/policy IDs are not identical values for all the benefits plans (medical, pharmacy, vision, dental, etc.) represented on the ID card. However, recognizing that this may hinder the adoption of a uniform health ID card standard, the Guide provides recommended specifications for combination ID cards when the values are not identical.

- **Credit card issuers** use the Issuer Identification Number (IIN) as managed by the American Bankers association. However, it is noted that check processing, wire transfers, direct deposits, bill payments, and other automated transfers of funds utilizes the Routing Transit Number (RTN) that was originated by the American Bankers Associations (ABA) in 1910. The ABA transit number appears on checks in two forms – a fraction form and magnetic ink character recognition (MICR) form. Both forms provide the same information, with slight differences. The nine-digit number includes a check digit.

Other identifiers that may be of interest include those associated with healthcare transactions, such as NUBC's UB-04 Health Plan ID Field and the **National Association of Insurance Commissioners sender and receiver identifiers.** In addition, other identifiers frequently cited as examples of successful identifiers include the National Drug Code (NDC) System, Social Security Number (SSN), and Vehicle Identification Number (VIN).

- **NUBC five-character payer ID** is assigned by either the payer or vendor that provides payment processing services. Although unable to confirm definitively, it appears that this five-character payer ID is that assigned by NAIC (see below). It is used to fill Block 51, Health Plan Identification Number, on the NUBC UB-04 claim form. It is noted that this field will be used to report the National Plan Identifier, once the identifier is defined. The code is generally used by the receiving payer to determine its respective payer lines (primary, secondary, or tertiary) on incoming claims.

- **National Association of Insurance Commissioners/National Insurance Producer Registry (NAIC/NIPR)** – as illustrated in the ACH Implementation Guide (May 2003) for the ASC X12 820 Version 4010, Premium Payment - Electronic Funds Transfer, the Interchange **Sender ID and Interchange Receiver ID are 9-digit numbers assigned by the health plan.**

[12] Peter Barry, Enumeron, 16th Annual WEDI National Conference, May 15-17, 2007.
[13] NCPDP Health Care Identification Card Fact Sheet: Pharmacy and/or Combination ID Card, November 2009, www.ncpdp.org/standards_purchase.asp

- **National Drug Code (NDC)** System provides a directory of products (over-the-counter, insulin formulations, herbal drugs, and prescription drugs) distributed in the U.S. Drugs listed under the NDC are identified by an 11-digit number divided into three segments. The first segment is assigned by the Food and Drug Administration (FDA) and identifies the vendor (or labeler) involved in the manufacturing, packaging, or distribution of the drug. The second segment is the product code and comprises the generic entity, strength, and dosage form. The third segment is the package code, and indicates the package size. The manufacturer assigns the second and third segments of the code for a given product, and is responsible for keeping this up to date on a quarterly basis. The directory includes the NDC, the product trade name, dosage form, routes of administration, active ingredients, strength, unit, package size and type, major drug class, and FDA approved application number (or "other" if not approved).

- **Social Security Number (SSN)** is issued to individuals by the Social Security Administration to track individuals for taxation purposes. The SSN is a 9-digit number with three parts. The first three digits are assigned according to the geographical region in which the SSN card is issued (prior to 1973) or the zip code in the applicant's mailing address (since 1973). The middle two digits are the group number, assigned by geographic groupings. These are not assigned in consecutive order. The last four digits are serial numbers, representing a straight numerical sequence of digits. There are some restrictions on use of certain numbers or number sequences. There is no check digit. Although it is possible to identify fraudulent SSNs, it is not easy using only publicly available information. It is further noted that the SSN is not necessarily the same as the Tax Identification Number (TIN) – which may the SSN, an individual tax identification number (ITIN) used to identify temporary visa holders, or the employer identification number (EIN) used to identify employers, sole proprietors, corporations, partnerships, non-profit organizations, trusts, estates, government agencies, and others.

- **Vehicle Identification Number (VIN)** is a unique serial number used by the automotive industry to identify individual motor vehicles. Since 1981, the VIN has consisted of 17 characters which do not include I (i), O (o), or Q (q). There are vehicle history services in several countries that can help potential car owners use VINs to identify branded vehicles and for other purposes. There are at least four competing standards used to calculate the VIN. Depending on the standard, the number may include a manufacturer identifier, vehicle attributes, model year, plant code, sequence number, and check digit.

In addition to the above identifier examples, the **Public Health Data Standards Consortium (PHDSC**) developed a **Source of Payment Typology** (Version 3.0) that has been incorporated into the October 2007 version (5050) of the ASC X12 837 Health Care Service Data Reporting Guide[14] which is not a HIPAA standard. The Consortium is a non-profit membership based organization of federal, state, and local health agencies; professional associations; academia; public and private sector organizations; international members; and individuals. This typology is used in public health and health services research for analysis of services by different types of programs.

The insert illustrates examples from the Typology.

PHDSC Payer Typology Sub-Committee
Examples from the Typology

1	Medicare
11	Medicare (Managed Care)
111	Medicare HMO
112	Medicare PPO
113	Medicare POS
119	Medicare Managed Care Other
- - -	
37	Local Government
371	Local – Managed care
3711	HMO
3712	PPO
3713	POS
372	FFS/Indemnity
379	Local, not otherwise specified
- - -	
5	Private Health insurance

[14] See www.phdsc.org/standards/payer-typology-source.asp

8.0 OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS

With respect to operating rules for health information transactions, NCVHS was tasked in the Affordable Care Act (Sec. 1104. (g)(3) to:

(A) Advise the Secretary whether a nonprofit entity meets the requirements for operating rules development;
(B) Review the operating rules developed and recommended by such nonprofit entity;
(C) Determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;
(D) Evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and
(E) Submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

8.1 Definition of Operating Rules

> The Affordable Care Act defines Operating Rules as the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.

The Affordable Care Act provides a definition for operating rules for health information transactions in Sec. 1104 (b) as in the insert.

Other industries also utilize operating rules – in general to describe the manner in which organizations operate and interact with others. For example, National Automated Clearing House Association (NACHA – The Electronic Payments Association) was established in 1974 to create uniform operating rules for the exchange of Automated Clearing House (ACH) payments among ACH associations and in compliance with the regulations of the Board of Governors of the Federal Reserve (12 CFR Part 370). The U.S. Federal Reserve and the Electronic Payments Network (sponsored by NACHA) maintain the operating rules. It appears that each of the major credit card issuers also have detailed operating rules describing types of members, their responsibilities and obligations, licensing and display of service marks, etc. (e.g., Cirrus Worldwide Operating Rules). There are operating rules for industrial trucks (e.g., to carry out the State of California Department of Industrial Relations regulations regarding the safety practices of trucks), the railroad industry (e.g., Operating Rules Association of North American Railroads), and how the IEEE Project 802 Ethernet Working Group performs its work – as further examples.

Until recently within health care, “operating rules” regarding technical connectivity, response times, and clarification of code usage have been embodied in companion guides developed by each health plan. As noted in the introduction to the HIPAA transactions and code sets (Sec. 2.2 in this Environmental Scan), over 1,000 such companion guides are in existence. Critics of the situation have identified that in addition to no single standard set of operating rules there is no requirement for use of a single set of operating rules or best practices and companion guides have been focused on health plan needs and insufficiently on providers’ business practices.

8.2 Purpose of Operating Rules for Health Information Transactions

The purpose of adopting standards and associated operating rules was set forth in the Affordable Care Act, Sec. 1104 (b)(4)(A), and were cited in the insert on page 6 as enabling determination of an individual’s eligibility and financial responsibility for services prior to or at the point of care, be comprehensive and requiring minimal augmentation by paper or other communications, support a transparent claims and denial management process, and describe all required data in unambiguous terms. The number and complexity of (paper and electronic) forms and data entry required by patients and providers should be reduced.

8.3 Health Information Transactions Operating Rules Development

The Affordable Care Act further provides requirements that a qualified nonprofit entity must meet to be considered for adoption. These include those specified in the insert below.

Affordable Care Act Sec. 1104. (g)(2) Requirements for Operating Rules Development
1. The entity focuses its mission on administrative simplification
2. The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations
3. The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.
4. The entity builds on the transaction standards issued under HIPAA.
5. The entity allows for public review and updates of operating rules.
Affordable Care Act Sec. 1104. (g)(2) Requirements for NCVHS Review of Operating Rules
a. Operating rules represent a consensus view of the health care stakeholders
b. Operating rules are consistent with and do not conflict with other existing standards
c. Operating rules are consistent with electronic standards adopted for health information technology

In addition to these criteria, the NCVHS has a set of well-developed guiding principles it has used in the process of making recommendations relative to standards. These are provided in Appendix A.

8.4 Current Stakeholder Efforts

Several States, consortia of States, and private organizations have identified the need for standard operating rules and have set about to both bring stakeholders together to create voluntary standards and to promote national adoption of one set of rules for all transactions. Although there may be several others, such groups have included those identified below.

Committee on Affordable Quality Healthcare (CAQH) created the **Committee on Operating Rules for Information Exchange (CORE)** as a nonprofit alliance of health plans and trade associations intended to support all payers.[15] Its goal is to develop a set of voluntary business rules that build on existing standards, such as HIPAA, to make electronic data transactions more predictable and consistent, regardless of the technology. CORE rules are modeled on business rules used daily in the banking sector for ATM transactions and airline industry for online reservations. CORE defines operating rules as the "rights and responsibilities of all parties [with respect to] security, transmission standards and formats, response time standards, liabilities, exception processing, and error resolution." CORE has stated that it is focused on creating operating rules and will not develop software solutions, a switch, a database or central repository of administrative information.

CORE Phase I rules were adopted in 2006; Phase II rules in 2008. Over 50 organizations are certified as exchanging electronic administrative data in accordance with either Phase I or II rules. CORE has widespread support from organizations such as Aetna, Blue Cross and Blue Shield Association, AAFP, ACP, AMA, Enclarity, HIMSS, Microsoft, and others. Colorado, Ohio, Texas, and Virginia have expressed interest in adopting the CORE rules for state initiatives. CAQH has authorized the Claredi certification testing solution from Ingenix (www.ingenix.com) to certify that healthcare organizations' IT systems are in operating in accordance with CORE Phase I rules, and Edifecs, Inc. (www.edifecs.com) to certify that healthcare organizations' IT systems are in operating in accordance with CORE Phase I and/or Phase II rules.

The Phase III Rules is in draft stage, and include rules for:

- Uniform use of claim status category and claim status codes
- Acknowledgements for v5010 837 Claims
- Companion guide template

[15] http://www.caqh.org/pdf/COREfacts.pdf

- Health care services request for review/response (278)
- Claim payment/advice (835)
- Real time 276/277 claim history availability
- Eligibility and benefits data content (270/271)
- Health insurance identification card

Linxus was initiated in 2004 when the Greater New York Hospital Association invited a group of health plans and providers doing business in the New York metropolitan area to come together to explore the possibilities of utilizing information technology to alleviate the high costs of health care administration. In early 2008, the participants voted to form Linxus as a nonprofit organization. Linxus members include Aetna, Emblem Health, Healthfirst, WellPoint (Empire Blue Cross Blue Shield), and eight hospitals in New York City and surrounding areas. Members pledge to implement technologies and process changes that are identified through the group's collaborative efforts. As of 3/27/09[16]

Linxus has created what it terms "single implementation specifications of HIPAA transactions" for:

- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Health Care Claim Status Request and Response (276/277)
- Health Care Claim Payment/Advice (835)

In addition to CAQH CORE and Linxus, States that have been identified as having created operating rules include Minnesota, Utah, and Washington.

8.5 Operating Rules vs. Companion Guides

In reviewing the work of CAQH CORE, Linxus, and States identified above, there does not appear to be a consistent use of terminology. Operating rules, companion guides, trading partner agreements, and even implementation specification (which are part of the ASX X12 standards) have been used synonymously or interchangeably. It is further noted that CAQH CORE includes a standard template for a companion guide within its operating rules; Linxus is silent on whether on whether its operating rules would be accompanied by companion guides.

9.0 Summary

The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010 supports improvements in administrative simplification (Sec. 1104) and adoption of additional standards for financial and administrative transactions (Sec. 10109). It calls for the National Committee on Vital and Health Statistics (NCVHS) to provide input into the process of rulemaking for the establishment of a unique health plan identifier and to provide advice and recommendations to the Department of Health and Human Services (HHS) relative to operating rules for electronic exchange of information not defined by a standard or its implementation specification.

This environmental scan serves as input to the NCVHS as it hears testimony from stakeholders to the health plan identifier (HPID) and, initially, with respect to authoring entities and operating rules for eligibility and claims status transactions.

[16] Version 2.0, Linxus Standard Implementation Specification, www.linxus.net

Appendix A: NCVHS Guiding Principles for Selecting Patient Medical Record Information (PMRI) Standards

Guiding Principles for Selecting PMRI Standards (June 20-21, 2000)

The principles proposed below are derived from the guiding principles developed to guide choices for the standards to be adopted by the Secretary of HHS that were published in the notice of proposed rulemaking for financial and administrative transaction standards. In developing its recommendations and legislative proposals, NCVHS will aim to promote PMRI standards that:

1. Improve the efficiency and effectiveness of the health system for delivering high quality care.

2. Meet the data needs of the health community, particularly providers, patients, health plans, clearinghouses, and public health organizations.

3. Will be consistent with the other HIPAA standards.

4. Have low additional standards development and implementation costs relative to the benefits of using PMRI standards.

5. Will be supported by an ANSI-accredited standards development organization, or other private or public organization that will assure continuity and efficient update of the standard over time.

6. Have timely developmental, testing, implementation, and updating procedures to achieve benefits faster.

7. Are vendor-neutral and technologically independent of the computer platforms and transmission protocols used in the electronic exchange of PMRI.

8. Are precise and unambiguous but as simple as possible.

9. Keep additional data collection burdens on users as low as is feasible.

10. Incorporate flexibility to more easily adapt to changes in the healthcare infrastructure (such as new services, organizations, and provider types) and changes in information technologies (such as new forms of data capture, knowledge representation, and information presentation).

11. Are consistent with the characteristics and attributes for clinically specific PMRI terminologies. Examples of these characteristics include in-depth and comprehensive coverage of a clinical area, the ability to map to broader statistical and reimbursement classifications, formal and systematic definitions, internal consistency and non-redundancy, and the capacity to evolve, change, and remain usable over time. (For the full set of characteristics, see ASTM E2087: Standard of Quality Indicators for Controlled Health Vocabularies.)

12. Are consistent with features and characteristics of data quality, including accessibility, accuracy, comprehensiveness, consistency, currency, definition, granularity, precision, relevancy, and timeliness. (For definitions of these features, see American Health Information Management Association Data Quality Management Model.)

13. Consider the degree to which the market has accepted each candidate PMRI standard.